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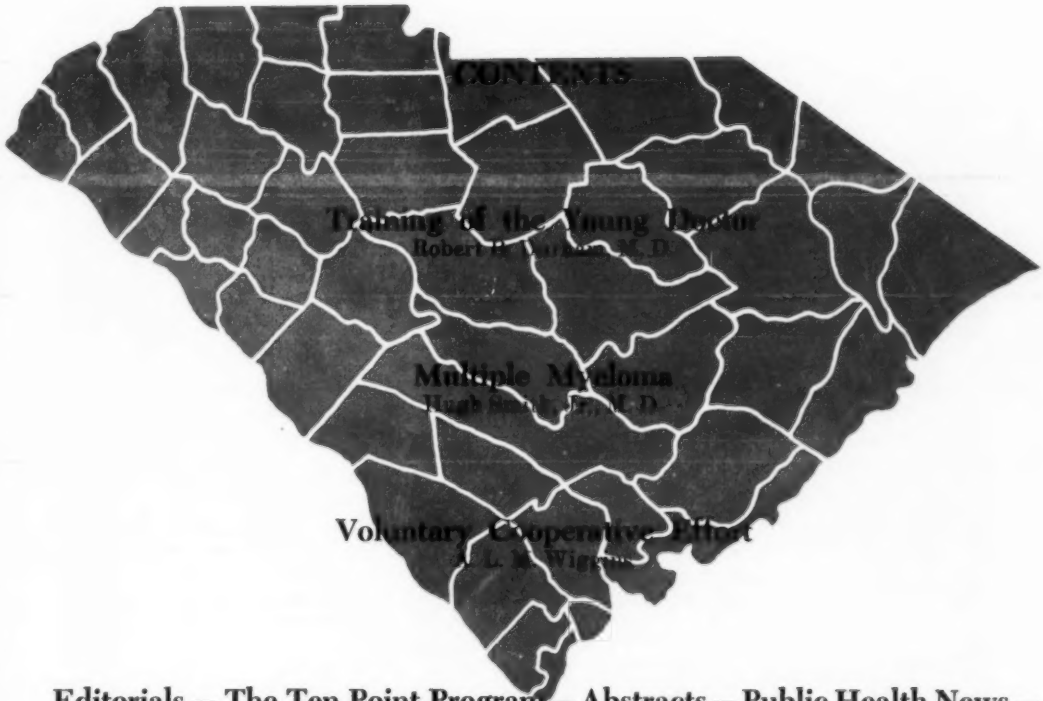

CONTENTS

Training of the Young Doctor
Robert [illegible], M. D.

Multiple Myeloma
Hugh [illegible], M. D.

Voluntary Cooperative Effort
[illegible]

Editorials — The Ten Point Program — Abstracts — Public Health News — News Items — Deaths — Births

OFFICIAL ORGAN OF THE SOUTH CAROLINA MEDICAL ASSOCIATION

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Council on Pharmacy and Chemistry, A.M.A.
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VOLUME XLV June, 1949 NUMBER 6

Training Of The Young Doctor

ROBERT B. DURHAM, M. D.
Columbia, S. C.

The subject which I am going to discuss is not a popular one, although one to which I have given careful thought for many years. It seems to me that some changes affecting the curriculum of medical schools could be worked out whereby some of the unnecessary or unessential subjects could be eliminated from the medical courses. Since we have added twelve grades to our school systems, thereby giving the pupil at least the equivalent of freshman work at college, his pre-medical courses could be shortened somewhere along the line in the course of his training; in high school, pre-medical studies or in medical schools. The young adolescent medical student is as ready for hard intellectual work as for anything else. There are many young men who would like to take up medicine as a profession but when faced with the staggering fact that it takes them twelve years before they can hang up their shingles, it is small wonder they choose some other profession.

Dr. R. B. Davis, of Greensboro, North Carolina has said: "It is hoped that some medical schools, somewhere, will launch out upon a practical medical educational program which will take the boys from the high school and enter them into a medical curriculum of six years, teaching English, public speaking, anatomy, physiology, pathology and pharmacology and including within these six years sufficient actual practical experience so that any who is willing to work and who has the determination to be a good doctor, can obtain his M. D. degree and his license to practice general medicine at the age of 24."

In the event a young doctor wishes to specialize, his years of training are further added to by the various Boards.

I am quite sure that 98% of our young doctors, graduating from medical college, successfully passing their State Medical Examinations and obtaining their licenses, would not attempt any procedure they felt they were not capable of handling, but if the various Boards continue to add on years of training, as they have in the past fifteen years—a man or woman will have reached the age of thirty-four or thirty-five before they are considered competent; or before they can begin making a livelihood. Many of our hospitals today have what is generally termed a "Closed Staff." You have to be a member of the Obstretical Board before you can deliver a baby in the institution. You have to be a member of the Board of Physicians before you can treat pneumonia or any other disease; or a member of the Surgical Board before you can lance an abscess or take out an appendix. It seems to me that this is a grave injustice to the young doctors who have devoted years of study to the art of healing. If this trend continues it will mean the passing out of existence of the *GREAT* general practitioner.

I would like at this point to quote from Dr. Thomas H. Lanman's Presidential address before the New England Surgical Society, Providence, Rhode Island, October 3, 1947. Dr. Lanman is professor of surgery at the Harvard Medical School. "I believe that the rules of the American Board of Surgery must be made more flexible and that they should be influenced by the sound and collective opinion of the members of this society. We should furnish our representatives on the various Boards with a clearer picture of the varying needs in the various communities." Already, conditions are quite different as far as the surgical training program is concerned from what they were when the Board of Surgery was organized. The war and its political sequelae have disrupted surgical training to a considerable degree. It is certain that the minimum requirements before a candidate can be certified by the American Board of Surgery are sound in principle but I believe there is need for a greater flexibility in their application. How many of our members meet the present requirements of the American Board of Surgery, as far as their formal training in length of internships and residencies is concerned? I know that I do not.

In his address as President of the American Ortho-

* Presidential Address delivered at Annual Session, S. C. Med. Assoc., May 18, 1949.

pedic Society, in June, 1946, Dr. J. Albert Key, of St. Louis, stated: "Due to the unswerving devotion to duty of the Membership Committees, our American Orthopedic Association comprises a group of orthopedic surgeons whose ability cannot be questioned; and yet, I doubt if ten percent of our present membership could meet the present training requirements. It is thus evident that it must be possible for one to become proficient in orthopedic surgery by other routes. I wonder if we are not making a grave mistake in our attempt to regiment the training of orthopedic surgery. To limit future orthopedic surgeons to those of our young medical graduates who can be forced into a mold is to exclude many whose qualifications justly entitle them to certification and whose abilities as orthopedic surgeons would be of great value.

"As the ward beds are encroached on by private and semi-private cases, there will be fewer and fewer cases under the care of the house staff. Coincidentally, and stimulated by the requirements of the American College of Surgeons and American Board of Surgery, more and more men desire a longer training period. Thus, the problem of adequate training for the young surgeon becomes increasingly difficult. No one will deny that increased training is a desirable thing, but where are the beds to train so many for so long? That would be difficult to answer in any event, but with the increasing shortage of ward beds it will become even more so. The answer to these questions must be forthcoming soon."

As this young correspondent points out, the so-called "Ward-beds" in the teaching hospitals are becoming fewer because of certain insurance plans, such as, the Blue Cross, as well as other factors. As a result, the opportunities for the proper surgical training of residents—particularly the actual operative work done by the house staff—are proportionately poorer. In passing, it is rather interesting to note his phraseology, "ward beds are *ENCROACHED* on by private cases."

I would like to quote from an article by the late Dr. Elliott C. Cutler, Professor of Surgery, Harvard University: "Twenty years ago a great many of our largest hospitals had a major number of so-called charity or free beds frequented by the poorer class where such people who could not afford the services of a private surgeon went to have their surgery performed. The teachers of surgery in the great schools were very jealous of their prerogatives as regards these "open" or charity beds because this was the material which they could utilize as they saw best in the final education of the young surgeon.

"The education of the surgeon and the physician differ essentially in that although many may profit from the examination of a patient with a cardiac murmur or some unusual medical sign, only the person who himself conducts the operative procedure can fully benefit from that experience. This handicraft aspect of surgery is something that must be learned and it must be learned under the most careful tutelage. After several years as an intern or assistant resident surgeon or fellow, the young surgeon reaches the point where he can not progress further unless he has individual surgical responsibility and the opportunity to operate independently and by himself. The experience acquired by such operations gives to the young surgeon confidence and practice which are essential to his final development.

"Shifting economic trends now are jeopardizing the existence of so-called charity or "open" beds in many of our greatest hospitals, either because the people are in large part becoming insured through group insurance systems, or because industry is taking over the care of its laborers and has its own doctors to look after them. Such patients are now private patients in the sense that a contract exists which places them under the care of specific individuals and their surgical care cannot be turned over to other than those mentioned in the contract. The number of "open" or charity beds is further diminished by the rising income of all workers which has now reached the level at which most hospitals could fill a greater percentage of their beds with paying patients."

In my humble opinion, after our young doctors finish medical school, pass the State Board of Medical Examiners, and take one year internship, they are qualified to begin the practice of medicine. If they intend to specialize they can associate themselves with a man in any of the various specialities, and work with him over a period of—say five to ten years—before he begins any of the various specialities alone. In this way, I think, we can produce much more competent surgeons, obstetricians, internists, urologists and so forth, for in this way, and this way alone, by getting their own hands into the work, and guided by those who have had vast experience they are far better trained than spending three to five years in a hospital as residents doing histories, physicals and general hospital routines.

These young doctors, at the same time, could be serving in a capacity that would be of vast help, not only to them in obtaining knowledge and experience, but could do much toward winning back the confidence and respect of the lay generally. From all quarters comes the same hue and cry "we cannot get a doctor at night." The public is being neglected as far as medical services are concerned. The young doctor is not to blame, the fault lies with us older men and the inflexible rules of our various Boards. Seventy-five percent of the young doctor's time must be devoted to his specialty. Small wonder Socialized or Federal Medicine is being forced upon us.

In 1910, with a population of ninety-two million in the United States, there were one hundred thirty-one medical schools; graduating four thousand four hundred students. In 1940, with a population of one hundred thirty-one million, there were seventy-seven

medical schools; graduating five thousand ninety-seven students. In these thirty years there has been a decrease of fifty-four medical schools, probably because they were classed as "B" or "C" schools; however, our profession has not made the "A" schools adequate to graduate enough medical students to serve the thirty-nine million increased population. An increase of only one thousand one hundred forty-three doctors in the same period of time!

We, as doctors, have failed in our duties.

As I see it—our Boards are laying too much stress on students with "A" grades in pre-medical work, and not enough on the aptitude of the individual. Far be it from me to take any credit away from "A" grade students, but so often this class, upon graduation, prefers science, chemistry, professorships or some highly scientific branch of medicine, rather than the practice of general medicine in rural communities, where the need is so urgent. The less skilled students in books, may actually make a finer doctor in practice than the Magna Cum Laude graduates. The answers to these questions must be forthcoming,—and soon.

Let us then meet at the fence, where the boundries join, work out a solution which will be advantageous to all persons concerned, defeat Socialized Medicine, and reclaim the admiration and respect of the communities to which we belong.

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Multiple Myeloma

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Joseph H. Pratt Diagnostic Hospital
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Although uncommon, multiple myeloma is not rare. Seven cases have been diagnosed at this hospital from the last 7,000 admissions. The diagnosis should be considered in any patient complaining of various bone pains, especially if he is anemic, shows evidence of renal damage, and has an extremely rapid sedimentation rate. Often the diagnosis can be made from simple laboratory tests that can be performed easily by any physician.

Recognition of the disease is important in order to be able to prognosticate correctly and to treat the patient wisely. Sometimes absolute proof of the diagnosis may be difficult although this is not usually true. The following brief report serves to illustrate a fairly typical case, but yet with negative tests for Bence-Jones protein in the urine and with three negative bone marrow aspirations.

CASE REPORT

A 61 year old varnish maker was first seen in the Clinic Consultation Service of the Joseph H. Pratt Diagnostic Hospital on March 30, 1949, with complaints of pain in the region of the left knee and right elbow for the previous two months. He stated that he was well until two years ago, when he noted the appearance of a tumor on his chest. This enlarged steadily for a month. After consultation, an X-ray diagnosis of giant cell tumor of the manubrium of the sternum was made and roentgen treatments were given with partial regression in size of the tumor. Following this, he got along fairly well until he fractured a rib while lifting a five gallon can of shellac. A year prior to admission, slight trauma led to a fracture of the 1 ft radius through a "bone cyst." This healed promptly. One month prior to admission he developed "bronchopneumonia." After recovery, he complained of moderate shortness of breath and pain in the left knee and right elbow. Films showed cystic areas in many bones and fluid in both pleural cavities, and so he was referred to this Clinic for study, He had lost 15 pounds in weight during the last two months prior to admission.

Prior to the present illness he had always been well except for malaria at the age of ten years, and an appendectomy at 44. He had worked for 29 years mixing shellacs and varnishes, working in high concentrations of alcohol and lead fumes.

Physical examination revealed a well developed, well nourished white man who did not appear ill. His temperature was 98.6 degrees F., pulse 90, respirations 20, blood pressure 180/100 mm. Hg., and vital capacity 3,200 cc. He had a hard, non-tender mass over the sternal manubrium about 10 cm. in diameter and 3 cm. deep, (Figure 1) and several smaller tumors involving various ribs laterally and posteriorly. A soft, blowing, systolic, aortic murmur was heard but no thrill was palpable. There was limitation of motion in the left knee and tenderness to firm pressure over the femur above the knee. Otherwise a complete

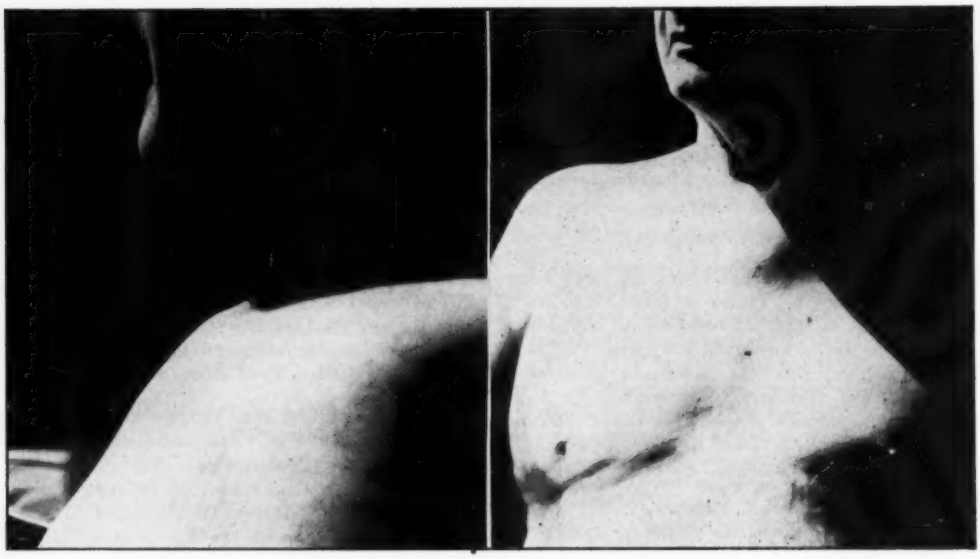

Figure 1.—Two views showing the tumor at the upper end of the sternum.

physical examination was within normal limits.

Laboratory studies revealed a blood sedimentation rate of 110 mm. per hour, 11.0 grams (70%) hemoglobin, 3,780,000 red blood cells per cu. mm., 4,750 white blood cells, with 55% polymorphonuclear leukocytes, 41% lymphocytes, 2% monocytes and 2% eosinophiles. There were 315,000 platelets per cu. mm., and 0.8% reticulocytes. There was a strong tendency to rouleaux formation noted on the smear. Urinalysis revealed albuminuria, a few red blood cells, a few white blood cells, and casts. However, the NPN was only 30 mg. percent. There was no Bence-Jones proteinuria. Serologic tests for syphilis were negative. Serum calcium, phosphorus, and alkaline phosphatase were within normal limits. The cholesterol was 104 mg. percent. His total serum proteins were 10.8 grams percent with 2.1 grams of albumin and 8.7 grams of globulin. Electrocardiograms were normal. X-rays revealed "numerous areas of destruction in the ribs, pubic bone, lower end of the left femur. There are numerous osteolytic round lesions varying in size in the right humerus, the lower end of the right femur and the skull. There is also destruction of the second lumbar vertebra."

Aspiration of the sternal tumor and of another area of the sternum revealed acellular marrow. Aspiration of the vertebral spinous process showed a hypocellular marrow. No myeloma cells could be found. Finally, surgical biopsy of a rib nodule revealed the typical picture of multiple myeloma, plasma cell type.

This case illustrates most of the usual clinical features of multiple myeloma. The disease is found in men twice as often as in women, and most commonly in the ages from 40 to 60, although it may occur at any age. There is no racial variation.

Multiple myeloma is a progressively wasting disease, but the diagnosis can usually be made before the wasting becomes obvious. Often the first symptom is pain, which may not be severe. This pain originates in the bone involved by growth of the myeloma cells. Often the painful area is near a joint and may cause a mistaken diagnosis of arthritis. There may be a fracture, following slight trauma, and X-rays, if showing a solitary cystic lesion, may be interpreted as evidence of a pathological fracture through a benign bone cyst or giant cell tumor.

In other cases a tumor growing in the sternum, rib, or skull may appear as the first evidence of myeloma. These tumors are highly vascular and are often soft, and may pulsate. Multiple nodules may appear later. When in the vertebrae, they may lead to painful skeletal deformities and various neurological abnormalities, of which paraplegia is the most common. The myeloma nodules may grow in the testes. Sometimes their growth from the ribs into the chest leads to hydrothorax, fibrinous or sanguinofibrinous pleurisy, in one or both pleural cavities. Microscopic examination of the aspirated effusion may lead to the diagnosis.

The kidneys are usually involved and may lead to uremia.[1] In fact, uremia without significant hypertension should strongly suggest the diagnoses of multiple myeloma, amyloidosis, or hypervitaminosis D.

Infrequently the liver or other organs may be involved.[2]

Laboratory studies nearly always reveal anemia, which is normochromic or hypochromic, and progressive. The erythrocyte sedimentation rate is frequently very rapid, often above 100 mm. per hour. There is elevation of the total serum proteins in about 50% of the cases. This is due to hyperglobulinemia, and may be extreme. Sometimes when the total protein value is normal, fractionation studies will reveal that there is still hyperglobulinemia but with hypoalbuminemia which keeps the total value from being elevated. Associated with the hyperglobulinemia, there is marked tendency for the erythrocytes to form rouleaux. This contributes to the rapid sedimentation rate. It is also easily seen on the slide stained for the differential white cell count. If extreme, it may interfere with the counting of the red blood cells in the counting chamber.

Bence-Jones protein is found in the urine in over one-half the cases. It has been intensively studied but the exact constitution and origin are still obscure. It is apparently a group of proteins of low molecular weight (35,000 to 37,000).[1, 3] It is not entirely specific for multiple myeloma, being rarely found in leukemia, osteomyelitis, bone tumors, and polycythemia,[4] but is a great diagnostic aid when present. Bence-Jones protein coagulates between 48 to 58 degrees Centigrade, then redissolves with further heating, only to reprecipitate on cooling. Albuminuria is frequently found, either with or without Bence-Jones proteinuria. The specific gravity is usually fixed and low. Casts are common; cells are rare. The NPN varies with the amount of renal damage, and is usually elevated terminally. Serum calcium is often elevated. The phosphorus is high or normal, helping to differentiate from hyperparathyroidism. Serum cholesterol is apt to be quite low, even down to 50 or 60 mg. percent. The basal metabolic rate is not elevated.

X-Rays are frequently diagnostic. Multiple "punched out" areas in the skull and ribs may make the diagnosis obvious. Often there is generalized osteoporosis. Sometimes there may be only osteoporosis or no X-Ray change in the diffuse type of myeloma without nodule formation. Solitary myeloma is uncommon but is more frequently found in the pelvis, dorsal vertebrae, or proximal portion of the femur.

The only positive way to diagnose multiple myeloma is by demonstrating the myeloma cells. They may be found in the peripheral blood smear in 8 to 10% of the cases. Aspiration biopsy of the bone marrow will usually demonstrate large numbers of the myeloma cells. However, if there has been X-Ray therapy over the tumor, as in our patient, aspiration may fail to show any cells. Then a surgical biopsy, preferably of a definite bone nodule will almost invariably provide the diagnosis.

At present, no curative therapy for multiple myeloma is known. However, definite palliation may be gained by use of roentgen treatments to the painful areas, and transfusions whenever the anemia warrants their administration. Rapid surgical decompression if the patient develops paraplegia may restore the nerve functions and enable the patient to be comfortable for many months, perhaps for several years. Stilbamidine has been reported to help some patients.[5] At this hospital and others,[6] however, not much benefit has been obtained through use of Stilbamidine, and urethane is being studied. Loge and Rundles[7] reported beneficial results with the use of urethane in four patients at Duke University Hospital recently. Harrington[8] reported "good results" in three patients and "probably good" results in three others among 11 cases treated with urethane at the Boston City Hospital for periods up to two years. It is hoped that further progress in the field of therapy will be made as other new drugs are developed.

SUMMARY

The diagnosis of multiple myeloma is suggested by: progressive anemia, rapid sedimentation rate, extreme rouleaux formation; albuminuria, casts, and low, fixed specific gravity of the urine; azotemia without significant hypertension; multiple bone pains and bone tenderness; and progressive weight loss and cachexia. The diagnosis is even more probable if the patient is a male between the ages of 40 and 60, especially if he has single or multiple bone tumors, Bence-Jones proteinuria, hyperglobulinemia, and "myeloma cells" in the peripheral blood smear, or characteristic punched out areas on X-Rays of the skull or ribs.

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Voluntary Cooperative Effort

A. L. M. WIGGINS
Chairman of the Board, Atlantic Coast Line Railroad Company, Hartsville, South Carolina

This meeting is the 45th anniversary of this association and is being held in the same city where it was founded in 1904. I am sure that the meetings through these 45 years have been invaluable to you in fellowship, in the discussions of subjects close to your lives and in the inspiration you have received to carry on a noble service in behalf of suffering humanity.

Equally significant is this 50th anniversary of the founding of the Relief Department of the Atlantic Coast Line Railroad Company. To me it is an inspiration to know that the directors and officers of this railroad system, before the turn of the century, had the vision, the sympathetic understanding of the problems and needs of the men and women who were associated in this enterprise, to set up a practical and workable and serviceable program to meet their needs against the adversities of illness and death. I can well imagine what courage it required for these directors to embark on a relatively new and untried venture in the conservation of human resources and in the protection of men and women against the vicissitudes of ill health. They were pioneers and the evidence of their foresight is that today, fifty years later, the people of this nation are just beginning to become aware of the importance of adequate provision of medical and hospital services on the basis of costs that will make possible the maximum use of such services.

I shall not attempt to present a history of the operations of the Relief Department of the Coast Line Railroad because I am sure that others who are better qualified will present the facts. I would like, however, to make a few observations about its operations.

In the first place, it is a cooperative undertaking based on the voluntary membership of those it is designed to serve. That it has commended itself to the employees of this railroad is proven by the fact that more than three-fourths of all permanent employees are members.

In the second place, it is not only cooperative among the members, but also as between the management of the railroad and the employees. Although the Coast Line does not contribute directly to the Relief Fund, it provides two hospitals with necessary equipment and the staff that is required for the operation and maintenance of the Relief Department as such, with an annual outlay by the Railroad of something over $100,000. Only last year the Company made a sizable expenditure for interior repairs, redecoration and modernization of these hospitals. The Relief Fund provided by its members bears the cost of the insurance, taxes, ordinary repairs and other costs of operation of the hospitals.

I believe you will agree that the operations of the Relief Department of the Atlantic Coast Line Railroad represent the finest degree of a wholesome interest on the part of an employer for the well-being of its employees that can be found. The facilities of these hospitals compare favorably with other hospitals, public or private, of similar size. One of them, with 75 bed capacity, is located at Waycross, Georgia, and the other of 50 bed capacity, at Rocky Mount, N. C. Their locations are convenient to the men working at any point on the Coast Line Railroad.

It is a matter of personal pride to me that the services provided and the quality of professional care that the patients receive in these hospitals are of the highest character. The members of the staffs are recognized by the medical profession as among the best.

All of this is provided at a cost to the individual of as little as 90 cents a month, which provides for medical treatment and hospitalization and, in addition, yields cash benefits for sickness, physical disability and death. Greater benefits may be had for those who desire it upon the payment of larger monthly dues.

You may be interested in knowing that the Relief Department operates under an Advisory Committee, of which six members are elected by the members of the organization and six appointed by the Company. The significant fact of the history of this management is that there has never been an instance in which matters under consideration for the operation of this department have received a tie vote. Every member of the Committee, whether representing employer or employees, is devoted to the one objective of providing the most for the least cost.

I present to you the splendid services of the Relief Department of the Atlantic Coast Line Railroad Company as an outstanding example of serviceable provision for the medical and hospital needs of people of moderate income at a cost they can afford to pay. The important fact is that this has been done by voluntary cooperative effort in which there is neither taxpayer subsidy nor the compulsion of governmental intervention.

I need not point out to this group of men whose lives are devoted to the service of mankind the many

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*(An address delivered before the Atlantic Coast Line Surgeons, Savannah, Ga., March 31, 1949.)

proposals now under consideration by the American people for some form of governmental compulsion in providing enlarged medical and hospital services for people of moderate means. Proposals have been made whereby the taxing power of government shall be used to provide these services. Some of the plans under consideration are recognized to be but the first steps toward the socialization of medicine. This is not at all a new idea. Many countries of Europe have had forms of socialized medicine, either compulsory or voluntary, which go back a hundred years. Germany instituted a compulsory health and disability insurance program in 1879. Great Britain passed its national health insurance act in 1911, and beginning 1948, substituted a general health service for everybody. Within recent years, most of the countries of Europe have moved into more complete systems of socialized medicine. These developments grew out of the trends toward socialization generally, but in the case of medicine were accelerated because of a combination of the ravages of war, the scarcity of doctors and hospital facilities and increased costs of modern equipment and facilities for medical treatment.

It is, therefore, no surprise that these developments in other countries should have an effect on the thinking in this country nor that some of the factors which have brought about socialized medicine in other parts of the world are present here.

You, better than I, know that more and more of our people are seeking medical and hospital service than ever before. When I was a boy, it was unusual for a person to go to a hospital except for a serious operation.

Doctors were available to come to the home any hour of the day or night, not only in the cities but throughout rural districts, often at considerable distance, and with great personal sacrifice, traveling by buggy over dirt roads in many cases, but taking care of the sick wherever they were as best they could. Of course, in those days having a doctor was resorted to only in extreme cases.

Today the situation is entirely changed. The public is better informed about health. There is a more frequent call upon the medical profession for diagnosis and treatment. Modern equipment is needed in many cases. Necessarily, there is less treatment in the home and more in the doctor's office and in the hospital. More lives are saved, more suffering relieved and now we have reached the point where every man and woman demands the accessibility of medical and hospital services, and what is more, at a price they can afford to pay.

As a banker in a small town for many years, I saw something of the financial hardships of working men when a member of their family had a long, serious illness that entailed expenses beyond their capacity to pay. In some cases, it required two or three years of saving for a man to meet his obligations. It is out of such situations as these that has grown a widespread demand for financing plans for medical and hospital care on a basis of some form of insurance whereby small amounts may be paid regularly that will provide against the cost of an unusual illness should it occur.

The American people are meeting this need to a substantial extent through voluntary associations and insurance programs of a voluntary nature. More than one-third of all people now have voluntary hospital insurance, one-sixth have surgical operation insurance and about one-fifteenth belong to medical care organizations. In addition, 31 million people have disability benefit insurance as sold by the insurance companies.

I am convinced that an adequate expansion of voluntary programs of medical and hospital insurance can meet the needs of the American people, with greater satisfaction, with more adequate service and with less cost than can any compulsory system paid for by the taxpayer and operated by the Government. I am equally sure, however, that unless more adequate provision is made for more people to secure needed medical and hospital services under plans that provide moderate regular payments, we may expect Government to play a continuing larger part in meeting this problem through some form of compulsory contributions. It seems to me that the question largely resolves itself into whether or not plans and programs will be further developed to meet these demands of the American people on a voluntary and cooperative basis or shall we stand by and see government undertake to do the job.

I am further convinced that once Government undertakes a compulsory program of medical and hospital insurance, it will be but a step toward the eventual socialization of medicine. The first step will be Government insurance to provide funds with which an individual may be able to pay his own doctor and the hospital of his choice. The next step will be the standardization of fees charged by the doctors. The third step will be to limit the number of patients a doctor may serve, and the final end will be the complete socialization of medicine with the doctors drawing their compensation as paid employees of the Government.

I have presented these possible developments rather brutally because I am fully convinced that a large part of public opinion is demanding greater security against the possibility of the heavy costs arising out of serious illness or accident. I am also convinced that with the medical profession now becoming fully alert and aware of this demand and of the threat of socialization, the doctors will work with each other and with other leaders who are interested in this problem to enlarge and multiply and improve tested plans that will meet the needs and the desires of the American people. You are thoroughly familiar with organizations

and efforts along this line and I think there is no better example of what can be done than the fine work of the Relief Department of the Coast Line Railroad over the past half century.

It is not only medicine that is confronted with the threat of eventual socialization. We have but to read the statute books of our land to discover that the concept of socialization has already permeated much of our national life. In this country, the railroads have not as yet felt the direct hand of socialization, but what has happened throughout the world to railroads is now beginning to cast its shadow here. In the early years of railroad transportation, before the advent of the automobile, the truck and the airplane, the railroad was virtually a monopoly in transportation. Government, therefore, seized control of the railroads in a tight clasp of regulation. In spite of the fact that these other means of transportation are now sharp competitors with the railroads, the firm grip of government regulation has not been relaxed. Laws are passed and regulations promulgated that force the railroads to engage in uneconomic practices. Made work without compensating value is created. The operation of some trains is required where the revenue produced is far less than the cost of the crew to operate the train. In many cases unrealistically low rates are maintained by Government fiat rather than determined by the economic value of the service performed.

Furthermore, the leadership of organized labor in the railroad industry has forced the railroads to pay for much work not performed, to set up uneconomic rules under which costs have multiplied without compensating benefit, either to the railroads or to the employees and there has developed a rigidity in the use of personnel that makes economic and efficient operation almost impossible.

Furthermore, Government has not been unkind to the competitors of the railroads. Tax money has built highways which in the course of a few years require rebuilding through their use by heavy trucks engaged in the transportation of property. Airports are built at public expense and air transportation directly subsidized out of the public treasury. Although the railroads carry 94% of all inter-city mail, they receive less for carrying this mail than the airlines receive for carrying the other 6%. Barge and steamboat lines operated at Government expense transport freight that would otherwise move by rail. The ironical fact is that part of the $1 billion per year the railroads pay in taxes is used by Government to subsidize their competitors.

Time does not permit a discussion of the problems of the railroads, but may I point out the fact that it requires more than men to operate a railroad. It requires capital and a lot of it. For every employee of the railroads of this country, there is an equivalent of more than $20,000 of capital investment to provide every job. That capital is indispensable to provide the roadway, the motive power, the shops and equipment. It can be acquired only through investment and investment money can be obtained only by paying it a reasonable rate of return. In only one year in the past twenty-eight have the railroads earned as much as 3% on their property investment, and last year the net return for all the railroads in the United States was only 4.38%. Within recent years, the railroads have secured the necessary capital for modernization, for new cars, for safety equipment and for modern motive power only through borrowing and through retaining most of their inadequate earnings for reinvestment in the property. More than two-thirds of the earnings of most railroads is retained for improving the property and paying off debt and the stockholder has had to be content with receiving less than the one-third remaining.

Only when the railroads are permitted to earn at least six or seven percent on their investment will they be able to attract adequate capital to meet their continuing needs for improvement, modernization and efficient operation.

It is a cold fact that unless railroads are able to finance their continuing capital needs, they will die of financial malnutrition. And here the spectre of socialization arises.

The railroads are indispensable to the welfare of this nation. Every day they haul 1.8 billion ton miles of freight, which is equal to hauling one ton for a distance of 12½ miles every day for every man, woman and child in the United States, and the remarkable thing is that they haul one ton one mile for less than 1⅓ cents. Truly, the cost of rail transportation is a bargain in these days of high prices.

To serve the American people in peacetime and to transport the essential supplies in wartime, the trains must run. It is unthinkable that the American people will permit the largest, the most efficient and the most economically operated transportation system in the world to die. The final recourse, no doubt, would be socialization. This is resort of most of the countries throughout the world.

We had a test of the Government operations of railroads in this country during World War I, and it cost the taxpayers $1,616,000,000. During World War II, under private operations, the railroads not only cost the taxpayers nothing and freight rates remained at pre-war levels, but in the four year period 1942-45, the railroads actually paid to the government in taxes an average of $2.5 million per day.

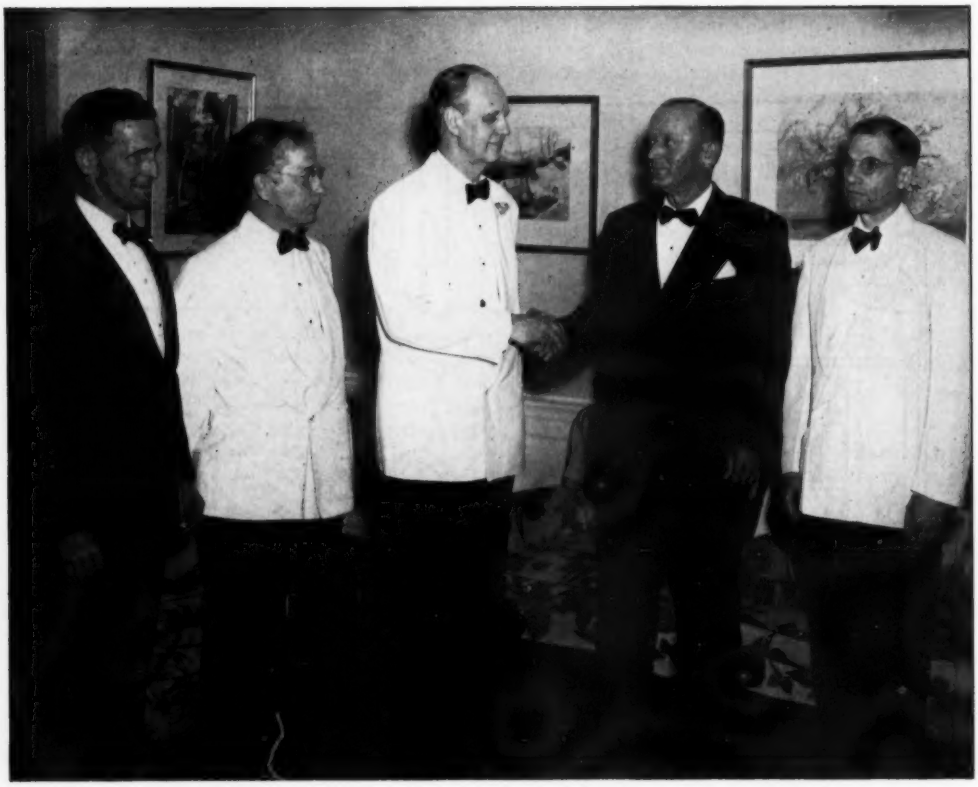
I believe that the correct answer is one that will appeal to the American sense of fair play and honest dealing. It is that we preserve the rail transportation system of this country through reasonable financial nourishment, proper rates, sound economic policies on the part of Government supervisory agencies, railroad

management and labor. With such environment, the necessary capital will be forthcoming, rail services will be further improved and the American people will be fully satisfied with its rail transportation system.

What is this socialism about which we are concerned? The best answer I can give is a recent statement in the London Sunday TIMES by Charles Morgan:

"BRITISH SOCIALISM. In England there is no incentive to bold undertakings . . . Today, it is safer to be a bureaucrat than a maker and the young men know it . . . Socialism is competition without prizes, boredom without hope, war without victory, and statistics without end. It takes the heart out of young men . . . it is not only politically false, but morally destructive."

"PLAYING ON THE JOB, EH? WE PAY YOU FOR YOUR MEDICAL SKILL, NOT YOUR PERSONAL INTEREST."



OFFICERS OF SOUTH CAROLINA MEDICAL ASSOCIATION 1949-50.

From left to right: Julian P. Price, Secretary-Editor; Archie Sasser, Vice President; Roderick Macdonald, President; Robert Durham, Retiring President; O. B. Mayer, Chairman of Council. (Absent when the picture was taken, W. R. Tuten, President-Elect).

The Journal of the South Carolina Medical Association

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Please send in promptly notice of change of address, giving both old and new; always state whether the change is temporary or permanent. Original manuscripts, subject to approval by the Editor and the Editorial Board, are desired for publication in the Journal. They should be typewritten, double spaced, on 8½ x 11 paper. References should be complete, and only such as relate directly to statements quoted in the paper. Illustrations will be used as funds permit, or as authors are willing to bear the necessary increase in cost. Short original articles are preferred to long reviews.

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JUNE, 1949

ROBERT SPANN CATHCART

The death of Dr. Robert Spann Cathcart brought to an end a life rich in accomplishments. He was among the first in South Carolina to specialize in surgery. He strove continuously to raise the standards of the medical profession, particularly of his chosen field. Dear to his heart was the Southern Surgical Association, of which he was at one time president. For many years he served as governor of the American College of Surgeons. As professor of surgery at the Medical College of the State of South Carolina, he exerted a profound influence over medical education in the state.

If it is possible to evaluate his many services probably the most valuable were those to the Medical Society of South Carolina. As chairman of the important finance committee he protected the large endowment funds, and saw them increase greatly during his lifetime. He was influential in the construction of the old Roper Hospital building which is still serving the community, and the Medical College for teaching purposes. To his efforts, in great part can be attributed the construction of the new Roper Hospital building, an accomplishment of which he could be justly proud.

Dr. Cathcart was a man of strong convictions. He fought hard to maintain what he thought was right. In spite of failing health, his interest in medical affairs continued to the end. In his death the medical profession loses a strong and valuable leader.

W. H. P.

1949 ANNUAL SESSION

More than four hundred physicians, not to mention their wives and guests, attended the recent annual meeting at Myrtle Beach. And from the opinions expressed generally, it was one of the most enjoyable and at the same time productive meetings ever held.

The Pee Dee Medical Association served as hosts and were most gracious with their hospitality. The entertainment furnished by the Liberty Life Insurance Company of Greenville was particularly acceptable and the annual banquet with Dick Reeves of Charleston as guest speaker, was outstanding.

The scientific papers were well received. The guest speakers are to be congratulated upon their addresses since they spoke in terms of the man in general practice and did not stray off upon the cloud of some specialty.

The House of Delegates holding an all day session for the first time in years worked seriously. Several subjects of marked importance were discussed and taken care of.

All in all the 1949 session will probably go down in history as a memorable one.

OUR NEW LEADERS

Dr. Roderick Macdonald of Rock Hill was installed as President of our Association for the coming year, succeeding Dr. R. B. Durham of Columbia. Dr. Macdonald brings to his task considerable experience in the work of the Association. First, as a worker in his own county and district societies, then as a member of Council and as Chairman of Council, and finally after a year as president-elect, Dr. Macdonald has seen what has been done and what needs to be done.

As President-Elect, the Association selected Dr. Wilbur R. Tuten, Sr., of Fairfax. A general practitioner in a small community Dr. Tuten brings to the Association a knowledge gained at first hand of the problems of general practice. Dr. Tuten has also served as a member of the State Board of Medical Examiners for a number of years, as a leader in his district medical society, and as Vice President of the Association.

The newly elected Vice President is Dr. Archie Sasser of Conway. A general surgeon, a community leader and builder, a member of the Board of Directors of the Blue Cross, Dr. Sasser will bring experience and sound judgment to the Association.

MEDICAL CARE PLAN

The ground work for a medical care plan was laid at the recent meeting of the House of Delegates. A

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committee headed by Dr. J. D. Guess, presented its report which called for the establishment of such a plan, and this was adopted unanimously.

Whether the plan will come to fruition and whether it will function will be determined by the members of the Association. Under the law, such a plan must have the signed endorsement and agreement to participate of fifty percent of the practicing physicians of the state before it can be operated.

The Plan, as proposed, has been presented in the Journal and the main features of the Plan will again be sent to all members of the Association. It is hoped that every physician in the state will study the Plan carefully and will be ready to become an active participant when the time arrives.

Voluntary prepayment medical care is the need of the hour. Otherwise, we may expect the compulsory insurance plan of Mr. Truman. South Carolina has been extremely tardy in making provision for a medical care plan and it will take hard work along with enthusiastic backing from all physicians to bring our state in line with our neighbors.

PEDIATRIC SEMINAR

The Southern Pediatric Seminar will hold its 29th Annual Session at Saluda, N. C. from July 18 to July 30. Indications point toward one of the highest attendances on record.

The Seminar is now accepted by the Academy of General Practice for credits toward post-graduate study. For this reason those of our members who belong to the Academy should be particularly interested in considering attendance this summer. A certain number of scholarships are available through the S. C. State Board of Health, and information concerning them may be obtained from Dr. Hilla Sheriff, Columbia, S. C.

TREATMENT SCHEDULES SOUTH CAROLINA PUBLIC HEALTH HOSPITAL, FLORENCE, SOUTH CAROLINA

A. Syphilis

Preparation used, Procaine Penicillin G in peanut oil, with 2% Aluminum Monostearate, each cc containing 300,000 units, injected intramuscularly.

1. The following schedule became effective June 9, 1948 for the treatment of primary, secondary, early latent, late latent, and congenital syphilis over 4 years of age and who are showing no late manifestations.

1st day	2cc	
2nd day	1cc	
3rd day	1cc	This makes a total of 3,-
4th day	1cc	300,000 units. Arsenical
5th day	1cc	and bismuth preparations
6th day	1cc	are no longer used.
7th day	1cc	
8th day	1cc	
9th day	2cc	

2. The following schedule became effective June 9, 1948 for the treatment of neuro-syphilis; primary and secondary cases which have relapsed; congenital syphilitics who show late manifestations i.e., gumma, paresis, tabes, interstitial keratitis; late manifest syphilis i.e., gumma of skin, Charcot's joint, late syphilis.

1st day	2cc	
2nd day	1cc	
3rd day	1cc	
4th day	1cc	
5th day	1cc	
6th day	1cc	
7th day	1cc	This makes a total of 6
8th day	1cc	million units.
9th day	1cc	
10th day	1cc	
11th day	1cc	
12th day	2cc	
13th day	2cc	
14th day	2cc	
15th day	2cc	

3. The following schedule became effective June 15, 1948 for the treatment of congenital syphilis in infants under 4 years of age.

Preparations: Penicillin Crystalline G injected intramuscularly.

40,000 units are injected every three hours until the patient has received 72 injections. This makes a total of 2,880,000 units.

4. The following schedule became effective June 23, 1948 for the treatment of CHANCROID and LYMPHOGRANULOMA VENEREUM.

Preparation; Sulfadiazine

First dose consists of 4 grams of sulfadiazine together with an equal amount of sodium bicarbonate.

Thereafter, the patient will receive 1 gram of sulfadiazine with an equal amount of sodium bicarbonate four times daily.

This schedule is given for five days, unless discontinued or prolonged at the discretion of attending physician.

5. The following schedule became effective June 28, 1948 for the treatment of GRANULOMA INGUINALE:

Preparation; Streptomycin dihydrochloride

One half gram is injected intramuscularly every 3 hours for 40 doses. This will make a total of 20 grams over a 5 day period.

If the patient has shown only slight improvement two months following completion of first course of streptomycin, he is given one half gram every three hours for 80 doses, making a total of 40 grams.

THE TEN POINT PROGRAM

M. L. MEADORS, DIRECTOR OF PUBLIC RELATIONS AND COUNSEL

MEDICAL CARE PLAN APPROVED

The House of Delegates in annual session at Myrtle Beach on Tuesday, May 17th, approved in toto, the report of the Committee on Medical Service, of which Dr. J. D. Guess of Greenville is Chairman.

The Report, and the approval by the House of Delegates included the fee schedule, prepared in advance by the professional committee appointed by Council, and the By-Laws which Council had previously approved.

The most gratifying feature of the whole procedure was the absence of argument or misunderstanding with respect to the fee schedule and general purpose of the Plan, and their general favorable acceptance by the House of Delegates.

Copies of the schedule, in mimeographed form had been mailed to the Delegates for study in advance of the meeting. Its acceptance is proof of its fairness and a tribute to the conscientious work of the professional committee in charge of its preparation.

On Sunday, May 22nd, the Board of Directors met in Columbia at the call of Dr. Guess, for the purpose of organization. The following officers were elected: Dr. J. D. Guess, Greenville, President; Dr. George W. Wilds, Hartsville, Vice President; Dr. George Dean Johnson, Spartanburg, Secretary; and Dr. J. D. Ashmore, Greenville, Treasurer.

Dr. Guess appointed several committees and these were directed to proceed at once with the preliminary work necessary to get the Plan into operation at the earliest possible date. As this is written, work is being commenced on subscription rates, contracts, and all of the numerous incidental procedures.

At the same meeting, Mr. Frank E. Smith of Chicago, Executive Director of Associated Medical Care Plans, was present and discussed at length the nature of the work of his organization, and gave valuable suggestions for guidance of the Board of Directors in setting up the South Carolina Medical Care Plan.

The Board voted to make application immediately for admission as an associate member of AMCP, and was assured that this would be favorably acted upon at the next meeting of the organization in Atlantic City, June 4th.

The entire fee schedule is carried elsewhere in this Department, and members of the Association are urged to give it their consideration. Steps will be taken in the very near future to secure the requisite number of participating physicians, so that the Plan may begin operating with as little delay as possible.

SCHEDULE
of
Professional Fees
State-Wide

THE SOUTH CAROLINA MEDICAL CARE PLAN

The Special Program
of the
South Carolina Medical Association

YOUR DOCTOR'S PLAN

FEE SCHEDULE

The fees listed in this schedule are the fees that will be paid by the Plan, directly to the attending physician. In the case of service indemnity (unlimited) subscribers, they will be the entire fee to be collected in each instance. In the case of cash indemnity subscribers (limited), they will apply on the total fee agreed upon by the physician and his patient.

In case of multiple, associated surgical procedures, the fee for all will be the largest fee for any one of them.

In case of multiple, non-associated surgical procedures, the general principle will be to set a fee at that of the major procedure plus one-half the fee for the minor procedure. However, such cases will receive individual consideration by the Central Professional Service Committee.

Surgical and obstetrical procedures not covered in the fee schedule will receive individual consideration by the Central Professional Service Committee.

Medical and Surgical conditions which come under the Workmen's Compensation Law are not covered by the contract with the subscriber.

DERMATOLOGICAL SURGERY

0001	Removal of benign skin lesions: Verrucae, nevi, keratoses, kaloids leukoplakia, etc. Depending on size and number (not including microscopic examination of tissue)	$5.00–$20.00
	Removal of malignant lesions of the skin; or mucous membrane (without x-ray therapy or microscopic examination of tissue)	
2	Up to 2.0 c.m. diameter	$ 35.00
3	More than 2.0 c.m. diameter	50.00
4	Biopsy and report	10.00

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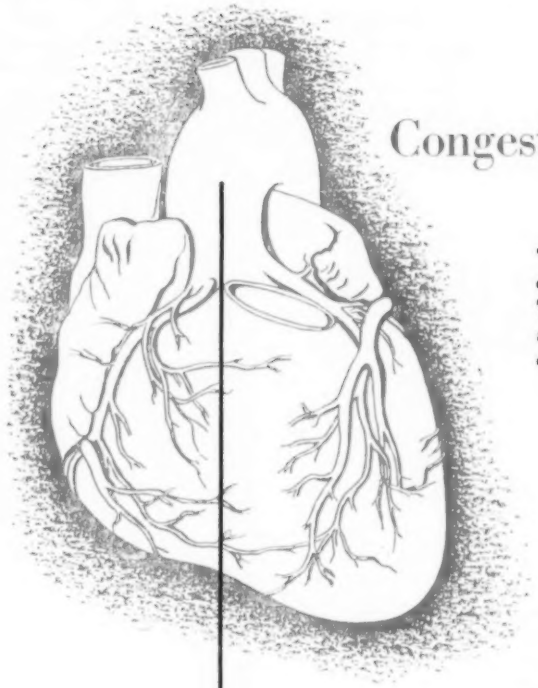
5	Avulsion of finger or toe nails	10.00
6	Removal of sebaceous cyst	10.00

EAR, NOSE AND THROAT

1091	Tonsillectomy and adenoidectomy —over age 15	$ 35.00
92	—15 or under	25.00
93	Tonsillectomy—under age 15	25.00
94	—over age 15	35.00
95	Adenoidectomy	15.00
96	Incision and drainage of peritonsillar abscess	10.00
1010	Incision and drainage of retro-pharyngeal abscess	20.00
11	Resection of ranula, resection—top	50.00
12	Ring operation	35.00
13	Removal of lymphoid tissue from pharynx and nasopharynx or electrocoagulation of same	25.00
14	Removal of foreign body from pharynx such as fishbone Simple direct, as from tonsil	5.00
15	Requiring indirect laryngoscopy (incision)	10.00
16	Removal of foreign body from hypopharynx or larynx by direct laryngoscopy	25.00
1020	Direct laryngoscopy (diagnostic)	10.00
21	Direct laryngoscopy and biopsy	35.00
22	Direct laryngoscopy and removal of benign tumor	50.00
23	Direct laryngoscopy and cauterization of tuberculous larynx	25.00
24	Direct laryngoscopy and dilatation stricture	15.00
30	Bronchoscopy (Diagnostic)	35.00
31	Bronchoscopy and lung mapping	40.00
32	Bronchoscopy and biopsy	35.00
33	Bronchoscopy with dilation of stricture, first	35.00
34	thereafter	25.00
35	Bronchoscopy and removal of foreign body	75.00
36	Bronchoscopy and removal of benign tumor (several bronchoscopies may be necessary)	150.00
37	Bronchoscopic removal of foreign body of lung with fluoroscopic guidance	125.00
40	Laryngofissure	100.00
41	Laryngectomy	150.00
1042	Arytenoidectomy	100.00
43	Tracheotomy	75.00
44	Plastic closure of tracheotomy wound	25.00
45	Thyrochondrectomy (removal thyroid cartilages)	75.00
50	Incision and drainage deep abscess of neck without tracheotomy	50.00
51	With tracheotomy	75.00
52	Biopsy of gland of neck	25.00
53	Removal of benign tumor of neck	50.00
54	Thyroglossal cyst resection	75.00
55	Branchial cyst resection	75.00
60	Ligation of great vessels of neck	35.00
61	Mixed tumor of parotid resection	100.00
62	Removal of submaxillary gland	50.00
63	Submucous resection	50.00
64	Submucous resection with cartilaginous transplant	100.00
65	Turbinectomy	10.00
70	Intranasal sphenoid and ethmoid, one side	50.00
71	both sides	75.00
72	Intranasal frontal	50.00
73	Intranasal antrum, one side	25.00
74	both sides	25.00
80	Electrocoagulation of turbinates (each side)	10.00
81	Radical operation for malignancy of sinus such as moure type of operation	100.00
82	External ethmoid	100.00
83	External frontal lynch type	100.00
84	External frontal complete with obliteration of sinus	125.00
85	External frontal with complete obliteration of frontal and wide exposure of dura (osteomyelitis of frontal bone)	125.00
1100	Radical antrum	75.00
1	Bilateral	100.00
2	Operation of congenital occlusion posterior nares (Depends somewhat on type of operation)	100.00
3	Antral irrigation	5.00
4	Incision and drainage of septal abscess	10.00
5	Removal of nasal polyps, one side	20.00
6	both sides	30.00
7	Reduction of nasal fracture	25.00
1110	Simple mastoidectomy	100.00
1	Double	125.00
2	Radical mastoidectomy without graft	125.00
3	With graft	150.00
4	Fenestration operation	150.00
5	Modified radical mastoid	125.00
20	Simple plastic for "flop" ear	50.00
21	Paracentesis of drum	5.00
22	Incision and drainage of canal wall abscess	5.00
23	Removal of polyps from ear	10.00
24	Removal of external ear for malignancy	50.00
30	Radical mastoid with drainage of petrous tip	150.00
1131	Mastoidectomy with packing off of sigmoid sinus	125.00
32	Diagnostic esophagoscopy	35.00
33	Diagnostic esophagoscopy with biosps	35.00
34	Esophagoscopy with dilatation of stricture	35.00
35	For subsequent up to total of 4	15.00



Congestive Heart Failure...

"The most striking effects were seen in cases of hypertensive heart failure. . . . There is a rapid fall in the raised right auricular pressure with a conspicuous increase in the output of the heart."[1]

SEARLE

AMINOPHYLLIN*

—improves cardiac failure by effecting an improved heart action with increased blood flow, and eliminating edema fluids by the renal route.

Searle Aminophyllin is indicated in paroxysmal dyspnea, bronchial asthma, Cheyne-Stokes respiration and selected cardiac cases.

ORAL—PARENTERAL—RECTAL DOSAGE FORMS

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

*Searle Aminophyllin contains at least 80% of anhydrous theophylline. G. D. Searle & Co., Chicago 80, Illinois.

SEARLE RESEARCH IN THE SERVICE OF MEDICINE

1. Howarth, S.; McMichael, J., and Sharpey-Schafer, E. P.: The Circulatory Action of Theophylline Ethylene Diamine, Clin. Sc. 6:125 (July 17) 1947.

36	Dilatation of cardiospasm under fluoroscopic guidance	35.00
40	Retrograde dilatation of esophagus	5.00
41	String dilation of esophagus	5.00
42	Esophagoscopy with removal of foreign body	75.00
43	Esophagoscopy and removal of foreign body from stomach without fluoroscopy	75.00
44	With fluoroscopy	100.00
45	Magnetic removal of foreign body of stomach with fluoroscopy	50.00
46	Diverticulectomy	100.00

EYE

2001	Barkan Operation	$ 50.00
2	Biopsy of conjunctiva	5.00
3	Blepharorrhaphy: suture of eye lid	10.00
4	Cataract—Intracapsular or extra capsular	150.00
5	Canthotomy	7.50
6	Chalazion excision—or incision and and curettage	15.00
2010	Conjunctiva flap for corneal ulcer	25.00
1	Conjunctiva flap with excision of iris for prolapse	75.00
2	Cornea—paracentesis	25.00
3	Corneal ulcer, cautery	7.50
4	Corneal Transplant	150.00
5	Cornea tattoo	50.00
6	Cyclodiathermy—ciliary body	50.00
2020	Dacrocystotomy	15.00
1	Dacryocystectomy	75.00
2	Drainage of lid—abscess	10.00
3	Entropian or Ectropion	50.00
4	Enucleation—with simple exoplant or implant	100.00
5	Evisceration	75.00
6	Excision of lesion of iris	100.00
30	Fulguration of eye lid (warts, etc.)	7.50
31	Glaucoma—Filtrating operation	100.00
32	Iridectomy optical	100.00
33	Intra-ocular foreign body	100.00
34	Intra-orbital foreign body	25.00
35	Lachrymal duct stenosis probing	10.00
36	Needling after cataract	25.00
37	Needling after congenital cataract	50.00
40	Pterygium	25.00
41	Perforating wound or cornea suture with or without conjunctiva flap	75.00
2042	Ptosis operation	100.00
43	Reattachment of retina	150.00
44	Removal of foreign body cornea	5.00
45	Refraction with mydriatic	7.50
46	Suture of conjunctiva	10.00
50	Squint—one stage	75.00
51	—two or more stages	100.00
52	Stye—drainage	5.00
53	Symblepharon	50.00
54	Tarsorrhaphy	50.00
55	Trichiasis—electrolysis	20.00
60	Tumor, exenteration of orbit	125.00
61	Toti—Mosher	125.00
62	Visual fields	5.00
63	Zanthomas (Excision) single	10.00
64	multiple	15.00

GENERAL SURGERY

Abdomen

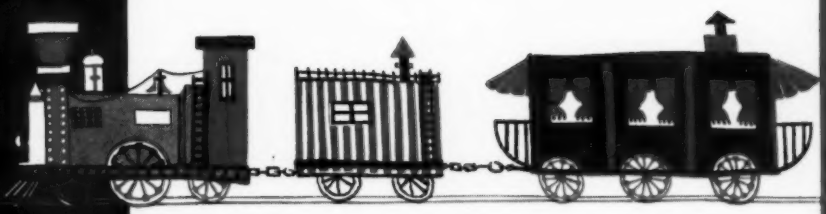
3001	Gastrotomy	$100.00
2	Gastro-enterostomy	125.00
3	Cholecystectomy	125.00
4	Cholelithiasis	100.00
5	Intestinal obstructions	100.00
6	Tumors in abdominal cavity	100.00
10	Wounds of abdomen—perforating	100.00
11	Exploratory laparotomy	$50.00—100.00
12	Gastric ulcer, excision	100.00
13	Gastrectomy	150.00
14	Peptic ulcer, closure, perforated	100.00
15	Duodenal ulcer, excision (Pyloroplasty)	125.00
16	Pyloric stenosis (Rammstedt's in infant)	75.00
20	Intestines (small) resection	100.00
21	Colon (resection) with one closure colostomy—individual consideration—maximum	125.00
22	Colostomy, palliative (no subsequent surgery)	75.00
23	Subdiaphragmatic abscess	100.00
24	Biliary surgical drainage, common duct and cholecystostomy	100.00
25	Diverticulum, intestinal—individual consideration maximum	125.00
30	Cholecystostomy	100.00
31	Cholecystoduodenostomy	125.00
32	Pancreas, drainage	100.00
33	Splenectomy	125.00
40	Freeing of adhesions	100.00
41	Esophageal, Diverticulum—one stage	100.00
42	—two stages	125.00
43	Pilonidal cyst—excision	50.00
3090	Appendectomy, simple	75.00
91	Appendectomy, drainage case	100.00
92	Appendiceal abscess—drainage	60.00

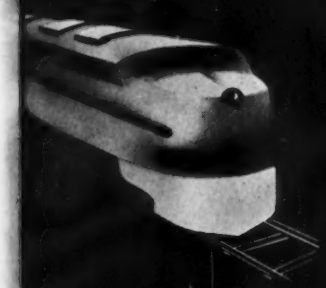
Breast

3101	Radical amputation	100.00
2	Simple removal	50.00
3	Removal of cysts, or benign tumor	20.00
4	Abscess or abscesses	20.00

Chest, Thoracic Surgery

3201	Complete Thorocoplasty	150.00
2	Pneumonectomy	150.00
3	Lobectomy	125.00
4	Removal of intra-thoracic tumor	125.00
5	Rib resection—drainage of empyema	50.00
6	Lung abscess—bronchoscope drainage	50.00
10	Phrenicectomy	30.00





the difference is noteworthy

Trimeton

(brand of prophenpyridamine)

TRIMETON* differs from most other antihistaminic agents in not being a derivative of ethanolamine or ethylenediamine. This difference is noteworthy and is responsible for the gratifying clinical results obtained. In one study of 227 patients with various allergic conditions[1]

83% obtained benefit from Trimeton

Side effects, common to all antihistaminics, occur with TRIMETON, but only a few patients find that they cannot tolerate the drug.[1]

Relief from allergic symptoms is usually obtained with one TRIMETON 25 mg. tablet three times daily; in some patients half this dosage is sufficient. The action of TRIMETON lasts from four to six hours.[2]

PACKAGING: TRIMETON (1-phenyl-1-(2-pyridyl)-3-dimethylaminopropane) is available in 25 mg. tablets, scored, in bottles of 100 and 1000.

BIBLIOGRAPHY: 1. Brown, E. A.: Ann. Allergy 6:393, 1948. 2. Wittich, F. W.: Ann. Allergy 6:497, 1948.

*TRIMETON trade-mark of Schering Corporation

TRIMETON

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11	Phenicotomy	30.00
12	Empyema, closed drainage (thoracotomy)	35.00
13	Pleura—paracentesis	7.50
14	Aneurysmorraphy	125.00
20	Open drainage of lung abscess	100.00
21	Esophagogastrostomy	150.00

Neck

3301	Thyroidectomy	100.00
2	Ligation (not followed by thyroidectomy)	35.00
3	Lobectomy (see chest)	125.00
4	Dissection of glands for cancer	100.00
5	Thyroglossal cyst	75.00

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3401	Unilateral	75.00
2	Bilateral	100.00

Rectum

3501	Hemorrhoidectomy—external	35.00
2	Fistula in Ano	40.00
3	Prolapsed rectum—cutting	75.00
4	Cancer of rectum	125.00
5	Ischiorectal abscesses or cysts perineal	25.00
10	Hemorrhoidectomy, internal	50.00
11	Polypectomy	25.00
12	Peri-rectal abscess—drainage	5.00

Tendons

3601	Repair one or more, individual consideration—maximum	$75.00—100.00
2	Lengthening	35.00
3	Resection of cysts of tendons	15.00
4	Septic finger—tendon sheath involvement	35.00
5	Septic hand, bad, sheath involvement and compartments	50.00

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	Abdominal (see 3006)	100.00
3701	Removal of malignant tumors, skin or mucous membrane	$35.00—75.00
	Other malignant tumors	35.00
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3801	Cutting operations, including injections, one leg	35.00
2	Both legs	50.00

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22	Removal of uterine polyp	35.00
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25	Atresia of Vagina—correction	20.00
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5001	Lumbar Puncture	$ 10.00
2	Cisternal puncture	15.00
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10	Laminectomy for spinal cord tumor	125.00
11	For chordotomy or rhizotomy	100.00
12	For extradural abscess	100.00
13	For traumatic paraplegia	100.00
14	For similar major conditions	100.00
20	Hemilaminectomy for ruptured disc, lumbar	100.00
21	Combined with orthopedic fusion	150.00
22	Hemilaminectomy for ruptured disc, cervical	100.00
5023	Resection of meningocele	50.00

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5101	Neurorrhaphy or Neurolysis	100.00
2	Neurolysis or neurorrhaphy combined with orthopedic operation	125.00
3	Neurolysis or neurorrhaphy combined with plastic operation	125.00
4	Neurectomy—resection of neuroma	50.00
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11	Biopsy of peripheral nerve	15.00
12	Resection of cervical rib	50.00
13	Section of scalenus anticus muscle	50.00

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5201	Sympathectomy—cervical or lumbar	125.00
2	Sympathectomy—staged or bilateral	150.00
3	Periarterial sympathectomy	75.00
4	Presacral neurectomy	100.00
5	Paravertebral sympathetic nerve block	15.00

Cranial Nerves

5301	Rhizotomy for tic douloureux	

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Advertisement

From where I sit *by* Joe Marsh

Remember How We Talked?

It went like this at the Hooper's last night. Hap's eighteen-year-old daughter is talking about "a real gone guy —solid—out of this world, but def."

"Now what kind of language is that supposed to be?" Hap barks. "Can't she speak English?"

"I'll translate it for you," Ma Hooper says, "in the language of the twenties, when you *were about twenty years old. She simply means this fellow is the 'cat's whiskers.' Remember how* we *used to talk sometimes?" Hap went back to reading his newspaper.*

From where I sit, it's easy to criticize the other person when we don't take a good long look at ourselves. Sure, there'll always be some differences. I'm fond of a temperate glass of beer and maybe you would prefer ginger ale—but let's just live and let live. Because when we go out of our way to find things to find fault with in others, chances are they can find a few in us.

Joe Marsh

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	Subtemporal approach	125.00
2	Injection or avulsion, peripheral branch. V nerve	15.00
3	Cerebellar craniotomy, section V, VIII, IX or X nerves	125.00
4	Combined with laminectomy	150.00
10	Anastomosis of cranial nerves	75.00
11	External section of cranial nerves for torticollis	50.00
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5401	Pneumoencephalography	25.00
2	Ventriculography	40.00
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4	Repair of laceration of scalp	10.00
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11	Craniotomy for osteomyelitis, skull	125.00
12	Craniotomy for skull tumor	125.00
13	Subtemporal decompression	100.00
14	Cranioplasty	100.00
15	Trephine and/or craniotomy for subdural hematoma	125.00
16	Extradural hematoma	125.00
17	Brain abscess	125.00
18	Craniotomy for tumor	150.00
19	Craniotomy for cerebral scar, aneurysm and similar major lesions	150.00
20	Resection of encephalocele	75.00
21	Craniotomy for congenital hydrocephalus	75.00
22	Pre-frontal lobotomy	125.00

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6090	Delivery of child or children and immediate postnatal care—in home, clinic, or hospital—normal or forceps	$ 50.00
6002	Caesarean Section	100.00
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7001	Wry neck (torticollis)	$ 75.00
2	Cervical ribs, removal of (or scalenotomy)	50.00
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11	Osteomyelitis of skull	75.00
12	Bone graft, jaw	125.00
20	Fracture, cervical spine a. simple	50.00
21	b. complex	100.00
22	Fracture jaw, upper	25.00
23	open	50.00
24	lower	35.00
25	open	75.00

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7101	Open reduction, old dislocation	125.00
2	Habitual dislocation of shoulder (Nicola, etc)	100.00
3	Osteotomies of humerus	125.00
	Birth palsy, shoulder and arm and forearm, combined	
4	a. With surgery (Sever, etc.)	100.00
5	b. Without surgery	50.00
10	Arm—chest adhesions, above elbow	100.00
11	Arm—chest adhesions, including forearm	150.00
12	Non-union humerus or clavicle (bone graft)	150.00
13	Tenotomies (or tendon plasty)	75.00
14	Shoulder resection or arthrodesis	150.00
20	Osteomyelitis of clavicle, scapula or ribs (sequestrectomy)	35.00
21	T. B. Shoulder without operation	50.00
7122	Osteomyelitis of upper extremities (sequestrectomy)	50.00
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24	Reduction, closed, dislocated shoulder	35.00
25	a. With fractured tuberosity	50.00
26	b. With fractured humerus—closed	50.00
27	—open	100.00
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32	Rib fracture, one or more	15.00
33	Sternum	15.00
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7201	Elbow resection or arthrodesis	100.00
2	Elbow arthroplasty or reconstruction	100.00
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5	a. Resection of head radius	50.00
6	b. Osteotomies of radius or ulna or both	75.00
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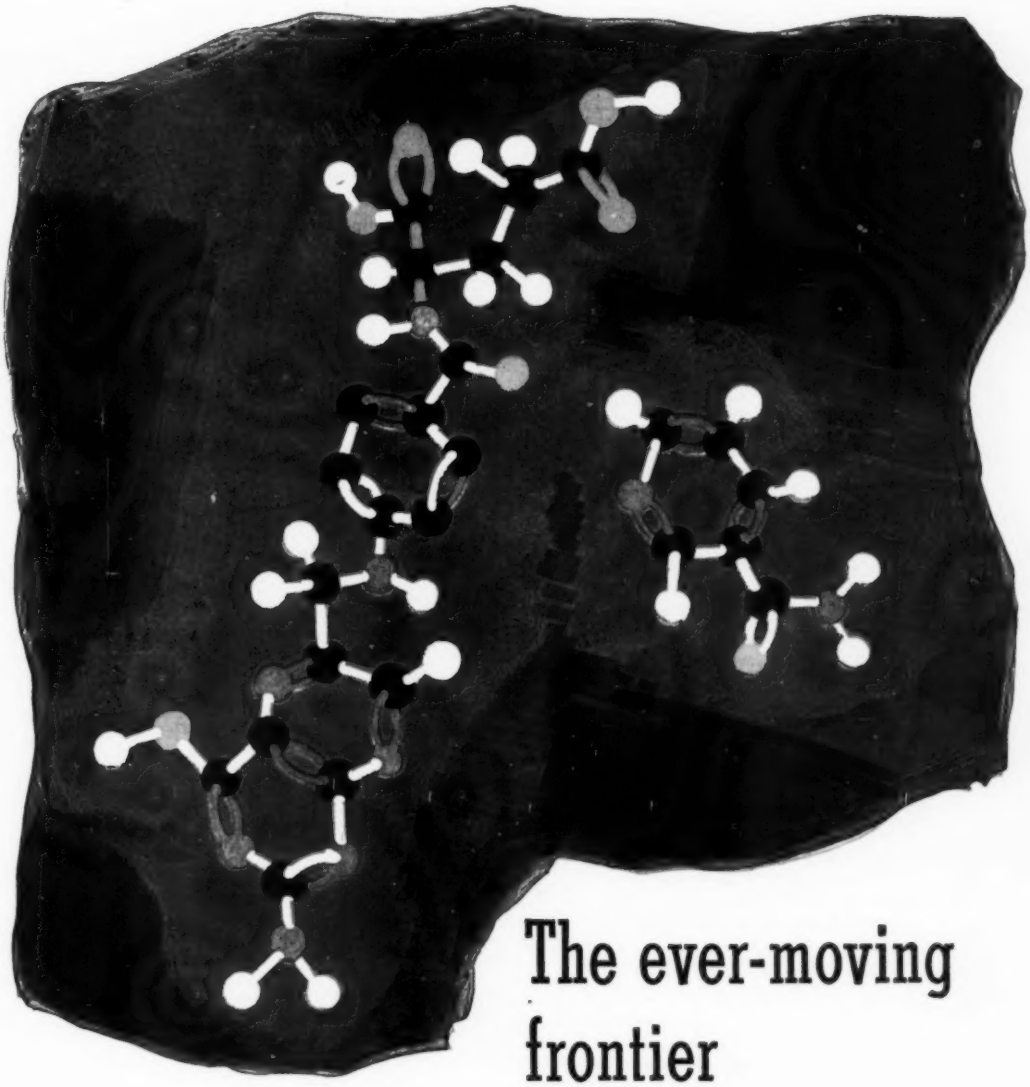
12	b. Undisplaced	30.00
20	Ulna, fracture—a. Undisplaced	25.00
21	b. Closed reduction	50.00
22	c. Open reduction (or compound)	75.00
30	Radius, fracture—a. Undisplaced	25.00
31	b. Closed reduction	50.00



The ever-moving frontier

Research on vitamin knowledge in the field of nutrition has come a long way since the early published researches of McCollum, Mendel and Funk. The science of nutrition is no longer the stepchild of medicine, nor the poor relation of agriculture. In particular, our understanding of the need for vitamins in human nutrition has enormously increased. Vitamins constitute in the aggregate the *sine qua non* for cellular respiration, reproduction, growth and repair.

For the past 25 years, biochemists have pressed forward a continually moving frontier of scientific discovery in the field of nutrition. In recent years, *Lederle* has been in the vanguard of this movement, its investigators being well known for their achievements with folic acid, pyridoxine, biotin, the pantothenates, liver extract, and allied substances. There will be no slackening in the efforts of this organization to uncover additional aids to better health and better living.

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32	c. Open reduction (or compound)	75.00
40	Ulna and radius fracture—	
	a. Undisplaced	25.00
41	b. Closed reduction	75.00
42	c. Open reduction (or compound)	100.00
43	d. Bone graft, single bone	125.00
44	both bones	150.00

Forearm, Wrist, Hand, Including Fingers

7301	Tendon transplant	100.00
2	Tenotomy of pronator quadratus—pronator raditeres	50.00
	Skin plasty—skin grafts:	
3	a. Wrist or palm of hand and fingers combined	75.00
4	b. Fingers only	50.00
10	Resection of wrist or arthrodesis	100.00
11	T. B. wrist (fusion)—cast	100.00
12	Club hands or osteoclasis, forearm bones	75.00
13	Closed correction of contractures, wrist and hand (post traumatic)	$35.00–75.00
14	Syndactylism—each two fingers	50.00
7315	Bone graft, radius or ulna	150.00
20	Amputation of finger (non-syndactylus), each	10.00
21	Tenoplasty (repair severed tendons) (and/or nerves)	$75.00–125.00
22	Joint resection, osteotomy or arthroplasty, finger	75.00
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31	b. open	75.00
40	Metacarpal fracture—a. simple	15.00
41	b. open (or compound)	25.00
42	(each additional, 50% more)	
50	Fingers, fracture—a. simple	10.00
51	b. open (or compound)	20.00
52	(each additional, 50% more)	

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7401	Spinal fusion	150.00
2	Spinal curvature—correction and fusion	150.00
3	T. B. Spine, without surgery (see casts) without fusion	50.00
4	Osteomyelitis, sequestrectomy and drainage	100.00
10	Dislocation, spine—closed reduction and cast	100.00
11	open reduction plus fusion	150.00
12	(or minus fusion)	125.00
20	Tendon or fascial transplant	150.00
21	Marie-Strumpell, per case (correction; casts; physio; x-ray therapy)	100.00
22	Fracture—closed reduction and cast	100.00
23	open reduction	150.00
24	Fracture of sacrum or coccyx	50.00
25	Laminectomy (2 surgeons) and fusion	Ind. cons.
26	Coccygectomy	75.00

Hip and Thigh or Pelvis

7501	Osteomyelitis of femur or pelvis with sequestrectomy	75.00
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3	T. B. hip or Perthes, without operation—cast or brace	50.00
4	T. B. hip with operation (fusion)	150.00
5	Congenital dislocation of hip (closed reduction)	75.00
6	shelf or fusion, or open reduction	150.00
10	Soutter fasciotomy	75.00
11	Arthroplasty, hip	150.00
12	Arthrodesis of hip	150.00
13	Subtrochanteric osteotomy (femoral osteotomy, manipulation and plasters)	150.00
14	Tenotomy of adductors	50.00
15	plus obturator neurectomy—(2)	100.00
20	Ober type fasciotomy—a. single	35.00
21	b. double	50.00
22	Sacro-iliac arthrodesis	125.00
23	Manipulation of hip and plaster	35.00
7524	Quadriceps plastic (Bennett operation)	150.00
	Slipped upper femoral epiphysis—	
30	a. closed correction	75.00
31	b. open correction (obstetomy and/or pinning)	150.00
40	Fractured hip, neck—a. closed	125.00
41	b. open	150.00
42	Fractured hip—trochanteric—a. closed	125.00
43	b. open	150.00
50	Pelvis, fracture	60.00
60	Dislocation, hip—a. closed	50.00
61	b. open	150.00
70	Fractured femur (traumatic) a. closed	100.00
71	b. open (or compound)	125.00

Knee

7601	Knock-knee or bow legs (osteotomy) femur or tibia: a. single	50.00
2	b. double	75.00
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11	T. B. of knee with resection of joint or fusion	150.00
12	Tendon transplantation	125.00
13	Tenotomy of hamstrings	75.00
14	Arthroplasty	150.00
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22	(both knees)	125.00
23	surgery with cast (one knee)	125.00
24	surgery with casts (both knees)	150.00
30	Fractured patella— a. closed (without displacement)	25.00

if she is one of your patients...

The farm housewife whose work is truly never done may find that the distressing symptoms of the climacteric make the smallest chore an arduous project. She depends on your help to resume normal efficiency in the performance of her daily tasks as well as to maintain a positive outlook during this trying period.

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	a. unilateral	35.00
46	b. bilateral	50.00

Legs

7701	Osteomyelitis tibia, single–	
	a. incision and drainage	25.00
2	b. sequestectomy	50.00
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	a. incision and drainage	25.00
4	b. excision or sequestrectomy	50.00
10	Ununited fracture or tibia, bone graft of	150.00
11	Osteoclasis tibia–a. single	50.00
12	b. double	75.00
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22	Fractured fibula	25.00
23	Fractured tibia and fibula, shaft	75.00

Ankle and Foot

7801	Potts' fracture–	
	a. closed reduction and cast	50.00
2	b. open reduction	75.00
3	Cotton fracture–	
	a. closed reduction and cast	50.00
4	b. open reduction	100.00
10	Ankle fusion	125.00
11	Triple arthrodesis (with transplantation)	125.00
12	Sprain–strapping	15.00
13	cast	35.00
20	Achilles lengthening–	
	a. unilateral	25.00
21	b. bilateral	35.00
22	Astragelectomy (ankle bone)	50.00
23	Os calcis–a. simple	50.00
24	(heel)–b. open (or compound)	75.00
31	T. B. or osteomyelitis, sequestrectomy and drainage	35.00
32	Plantar fasciotomy (alone)	25.00
33	Arthrodesis–subastragalar complete (Hoke foot stabilization)	100.00
34	Clubfoot, congenital (single or double) casts or Dennis Brown splints–each visit	7.50
35	Correction for flatfoot;	
	a. cast and wedging	$25.00–45.00
36	b. reconstruction, single	100.00
37	c. reconstruction, double	150.00
40	Amputation of toe	10.00
41	Tendon transplantation of foot (alone)	50.00
42	Tenoplasty of foot or toe (repair of severed tendon, one or more)	25.00
43	Operative correction of bunion:	
	a. single	50.00
44	b. double	75.00
50	Wedge osteotomy or resection	50.00
51	Skin plasty or skin grafts, foot	$35.00–50.00
52	Drop foot bone block, operation, alone	75.00
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54	Excision, toe nail (in-grown) each	5.00
60	Scaphoidectomy–a. single	35.00
61	b. double	60.00
62	Clawfoot (complete with toe surgery)	125.00
63	Hammer toe (alone) each	15.00
	Tarsal or metatarsal fractures or dislocation (each):	
64	a. closed (each additional 50% more)	20.00
65	b. open (or compound) (each additional 50% more)	35.00
7870	Toe, a. closed	10.00
71	(each additional 50% more)	
72	b. open (or compound)	20.00
73	(each additional 50% more)	

Miscellaneous

7901	Amputations:	
	a. Thigh–above trochanter	125.00
2	b. Thigh–below trochanter	100.00
3	c. Leg, below knee	75.00
4	d. Forefoot	50.00
5	e. Shoulder (scapulo-humeral)	150.00
6	Shoulder (humeral)	100.00
7	f. Below elbow (forearm)	75.00
	g. Finger or toe (each)	10.00
8	h. Metacarpal or metatarsal	50.00
10	Manipulation of joint adhesions, each (major joints)	15.00
11	Removal of bone tumors other than simple exostosis	100.00
12	Extensive skin grafting, including tube grafting	100.00
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21	Ganglion, wrist	35.00
22	Exostosis (one or more)	50.00
23	Biopsy	25.00
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UROLOGY

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8001	Adrenalectomy or exploration	$150.00
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3	Excision, renal fistula	50.00
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12	Nephrectomy or heminephrectomy	150.00
13	Nephrolithotomy	150.00
14	Nephrostomy	100.00
15	Nephropexy (includes management of anomalous vessels)	100.00
20	Symphysiotomy and nephropexy (horseshoe kidney)	150.00
21	Pyelolithotomy	125.00

Ureter

8101	Incision and drainage, peri-ureteral abscess	75.00
2	Plastic repair, ureteropelvic juncture	150.00
3	Ureteropelviostomy	150.00
4	Ureterocystoneostomy	150.00
5	Ureter, anastomosis of	150.00
6	Ureterosigmoidostomy	150.00
8107	Ureterostomy, cutaneous	100.00
8	Ureterolithotomy	125.00
9	Ureterotomy (tumor or stricture)	125.00

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8201	Cystotomy	75.00
2	Cysto lithotomy	100.00
3	Cystotomy, fulguration of tumor	100.00
4	Cystotomy, implantation of radium (radium not included)	100.00
5	Cystectomy, partial resection	100.00
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8	Vesicovaginal fistula	100.00
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8301	Incision and drainage, abscess	75.00
2	Prostatomy, for stone	75.00
3	Prostatectomy, perineal	150.00
4	Prostatectomy, suprapubic (includes cystotomy)	150.00
5	Prostatectomy, transurethral	100.00
6	Repair, recto-urethral or perineal urethral fistula	100.00

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8401	Incision and drainage, abscess	75.00
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8501	Hydrocele, excision	50.00
2	Hydrocele, tapping	5.00
3	Epididymectomy or epididymotomy	50.00
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6	bilateral	75.00
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8	Plastic for elephantiasis	100.00

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8601	Amputation, simple	50.00
2	radical	100.00
3	Biopsy	5.00
10	Circumcision, under 15	10.00
11	over 15	25.00
20	Dorsal slit—in office	5.00
	—in hospital	10.00
21	Excision penile urethral fistula	75.00
22	Meatotomy, urethral	10.00
24	Caruncle in female, excision	10.00
25	Prolapse of female urethra resection	35.00
30	Urethrotomy, external	75.00
8631	Urethrotomy, internal	25.00
32	Dilation of stricture	5.00
33	Incision and drainage, periurethral abscess	25.00
34	Extravasation (without cystotomy)	50.00
35	Urethroplasty, stage operation	150.00
36	Plastic repair of chordee	50.00
40	Fulguration of warts—in office	5.00
	—in hospital	10.00
41	Fulguration of Caruncle	
	—in office	5.00
	—in hospital	10.00

Cystoscopy, Diagnostic and Operative

8701	Observation cystoscopy, initial	10.00
2	subsequent (limited to $30.00 each adm.)	5.00
3	Cystoscopic ureteral catheterization and/or dilation	25.00
4	Extraction of ureteral stones	50.00
5	Litholopaxy	75.00
10	Fulguration, ulcer or papilloma	25.00
11	Resection and fulguration of carcinoma	75.00
12	Biopsy of tumor	25.00
13	Implantation of radium (radium not included)	25.00
14	Ureteral meatotomy	25.00
15	Resection urethral polyps	25.00
16	Removal of foreign body (not stone)	50.00

MISCELLANEOUS (SURGICAL PROCEDURES ONLY)

9001	Superficial abscesses and boils—incision and drainage	$ 3.00
2	Other-deep-incision and drainage—individual consideration—maximum	20.00
3	Deep cervical abscesses—individual consideration maximum	50.00
10	Carbuncle—excision	30.00
11	Ulcer—excision	10.00
12	Pinch grafts	Ind. Cons.
13	Other skin grafts	Ind. Cons.
14	Suturing of wounds	Ind. Cons.
20	Cysts, sebaceous, removal	10.00
21	Dermoid cysts	Ind. Cons.
22	Glands, superficial removal	7.50

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..."for services

WHO shall measure devotion, or put a price on sacrifice?
Who shall assess the long war against the power of Death?
Or set a sum upon the gift of Life?

There is a service beyond the measure of a fee.
A cause above remuneration.
An ideal for which there is no price.
This is the service...the cause...the ideal...of the American doctor.

How shall we reckon it, and by what formulae?
How much for the laughter of a little child rescued out of crisis?
What's the cost of discouragement?
Who can pay for a sleepless night?
Name the price of a cure!

AMERICAN DOCTOR

rendered..."

There is no algebra for it, no scribble of figures, no proper value.
For this is a service as large as life, and as manifold.
It is a soldier crying in agony on a thousand battlefields.
It is the terrible word "Why?" under the surgeon's probe.
It is the end of pain.
It is Hope.
It is the lonely, unending quest for knowledge.
It is the fight against ignorance, sloth, superstition.
It is the dumb, unspeakable joy in the eyes of a parent.
It is the rock of grief.
It is cold rain and pounding storm and bone-weariness and the new-born babe gasping its first breath in the grey dawn.
It is all this, and the quiet glory of the job done,
Dedicated to service—in the name of Mercy
And the common brotherhood of man.

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	Dissection of glands of neck for cancer (see neck No. 3303)	100.00
30	Toe nail, ingrown, removal	10.00
31	Pericardium, paracentesis	10.00
32	Pneumolysis	50.00
33	Cardiotomy	Ind. Cons.
34	Abdomen—paracentesis	7.50
35	Mucosa, excision of redundant	10.00
36	Aspiration of joint	10.00

OTHER MISCELLANEOUS PROCEDURES

9101	Blood transfusions—	
	—Direct from donor to patient	25.00
2	—Infusion (over 2 yrs. of age)	5.00
3	—Infusion (under 2 yrs. of age)	10.00

DIAGNOSTIC X-RAY

INJURY OR ACCIDENT CASES ONLY

Finger or toe	$ 5.00
Hand or foot	7.50
Extremity, other than above	10.00
Shoulder	10.00
Pelvis	10.00*
Hip	10.00
Hip pinning procedure	25.00
Nose	10.00
Facial bones	15.00
Sinuses	15.00
Mastoids	15.00
Jaw	10.00
Skull	15.00
Encephalography	25.00
Spine, one section	15.00
Spine, two sections	20.00
Spine, entire	25.00
Mylography	10.00
Ribs	10.00
Pelvic encephalography	20.00
Chest	10.00
Bronchogram	20.00
Eye, Sweet localization of foreign body or equivalent	25.00
Urinary Tract	10.00
Pyelogram	15.00
Fluroscopic aid in reduction of fracture	5.00
Fluroscopic examination when no films are made	5.00

X-Ray fees of over $25.00 for one case will receive individual consideration.

ABSTRACTS

Friedman, M. H. F. and Haskell, B. F.: Treatment of Non-specific Ulcerative Colitis for One Year with Extracts of Intestinal Mucosa.

(Gastroenterology 11:833-842, Dec., 1948)

The authors suggest that non-specific ulcerative lesions of the bowel may be due to the absence of an intrinsic factor normally associated with the intestinal mucosa and have treated 27 patients with intestinal extracts for a period of one year or longer. All had proved refractory to other therapies.

A crude extract of intestinal mucosa was used in a daily dose of 50 to 100 grams in divided portions. With improvement this amount was reduced to what was considered a maintenance dose.

Distinct evidences of improvement were shown by 24 of the 27 patients after 2 to 5 weeks of treatment. In patients with frequent bowel movements the first sign of improvement was reduction in frequency, followed by a disappearance of blood and decrease of mucus from the stool, and finally a return of stool consistency towards normal. The rectosigmoid showed decrease in friability, gradual healing of the ulcers, disappearance of edema, absence of mucus, and a return of the normal colon and elasticity of the mucosa. The mucosal changes were noted only several weeks after symptomatic improvement was evident. Relapses during treatment were infrequent, of short duration and usually in connection with upper respiratory tract infections. Withdrawal of treatment or substitution of a placebo, or use of intestinal extracts prepared by a different method resulted in a relapse with remission recurring on resumption of treatment with an effective extract. The authors found that patients less severely affected responded more promptly.

Terrell, Jr. C. O., and Hoar, C. S.: Streptomycin In the Treatment of Hemophilus Influenzae Laryngotracheobronchitis; The J. of Ped.; 34:139; February, 1949.

The authors present four cases of H. influenzae laryngotracheobronchitis in young infants successfully treated with streptomycin whose ages ranged from nine weeks to six months with two of them being four months of age.

The history and physical in all four cases were similar. The present illness began anywhere from 4 days to 1 week prior to admission and was characterized by an upper respiratory infection with rhinitis, nonproductive cough, anorexia, and low-grade fever. These symptoms in all cases progressed in severity and on admission the infants exhibited fever, rapid, wheezing respiration, and cyanosis. Physical examination revealed dyspnea with markedly increased

respiration, elevated temperature, inflamed pharynx, rales over both lung fields, and a white count ranging from 10,700 to 16,750. A throat culture was taken immediately. In all but one case the initial report showed H. influenzae. In this case, the infection was of a mixed type but a subsequent culture revealed the H. influenzae.

The immediate treatment consisted of continuous oxygen, penicillin 15,000 units intramuscularly every 3 hours, and a vapor tent. As soon as the cultures were reported as positive for H. influenzae, streptomycin was started with 50 mgm. intramuscularly every 3 hours. Within 12 hours the infants' respirations were markedly improved and the temperatures fell by crises shortly afterwards. The infants were discharged anywhere from the 6th to the 10th hospital day.

The authors suggest that streptomycin be given immediately to all cases of laryngotracheobronchitis occurring in young infants and continued until the throat culture reveals a nonsusceptible organism. The authors have found no ill effects from streptomycin given for such a short time.

PUBLIC HEALTH NEWS

4 CARDIAC CLINICS PLANNED FOR THE STATE

Plans for the establishment of four regional cardiac clinics at focal points in the state were made at a recent meeting of the Board of Directors of the South Carolina Hospital Association. Tentative plans were made to establish other clinics as fast as money is made available through contributions to the Association. The Board also made available an annual fellowship in cardiology at the Medical College of South Carolina to be awarded to a physician in the state selected by the Medical College.

The Board of Directors of the South Carolina Heart Association consists of one physician from each of the nine medical districts in the state, and three lay members-at-large. There are no local chapters, although 19 counties were organized this year for the purpose of fund raising only. Next year all 46 counties will be organized for that purpose.

Members of the Board of Directors are: Dr. John A. Boone, president; Dr. Izard Josey, vice president; Angus E. Bird, treasurer; H. M. McElveen, executive secretary; Dr. O. Z. Culler, Dr. Hugh Smith, Dr. Charles White, Dr. W. J. Nelson, Dr. S. H. Shippey, Dr. W. L. Pressly, A. L. M. Wiggins, Dr. W. R. Mead, and Wilton Hall.

CHARLESTON TO BE HEART RESEARCH CENTER

Dr. Ben F. Wyman, State Health Officer, has been notified by the U. S. Public Health Service that Charleston has been selected as one of three sites in the United States where research centers for heart diseases will be established. Other heart centers will be in Massachusetts and Indiana.

The heart disease program will consist of fact-finding and follow-up activities for cardiac cases treated by the physicians of Charleston. The heart center will be operated by the U. S. Public Health Service and local public health officials, but the program to be followed will be determined by the doctors of Charleston.

Patients will not be treated or diagnosed at the heart center, but will be studied over a period of time to determine the effects of treatment, diet and other factors recommended by the Charleston doctors associated with the program.

Before the decision was made to establish the demonstration unit in Charleston, it was necessary to gain the approval of the State Board of Health, the South Carolina Medical Association, the Medical Society of South Carolina (at Charleston) and the Charleston County Board of Health.

The heart center will be staffed with heart specialists, nurses, educators, and other personnel. South Carolina and Charleston were selected over a number of other states competing for the heart center.

NEWS ITEMS

Dr. Hillyer Rudisill, Jr. has opened his office for the practice of radiology at 145 Rutledge Avenue, Charleston.

Dr. J. Harvey Atwill of Columbia, and Dr. Harold L. Sanders of Greenville have volunteered for duty with the armed forces.

Dr. John R. Harvin has opened an office in Columbia for the practice of pediatrics. Dr. Harvin formerly practiced in Sumter.

Dr. W. Cyril O'Driscoll has been promoted to professor of anatomy at the Medical College of South Carolina. Announcement of his promotion from associate professor to a full professor was made by the Medical College Dean, Dr. Kenneth M. Lynch.

DEATHS

ROBERT SPANN CATHCART

Dr. Robert S. Cathcart, noted surgeon of Charleston, died at his home on April 29 at the age of 77. He had been seriously ill for several weeks.

Dr. Cathcart was born in Columbia, September 25, 1871. He attended the Columbia schools and the school of pharmacy of the University of South Carolina and received his degree in pharmacy in 1890. Three years later he was graduated from the Medical College of South Carolina. After a period of internship in the hospitals of Charleston, he engaged in the general practice of medicine for fourteen years before going into surgery. Dr. Cathcart actively practiced medicine for over fifty-five years.

Surviving Dr. Cathcart are his widow, the former Miss Katherine Morrow of Birmingham; two sons, Robert S. Cathcart, Jr., and Dr. Hugh Cathcart, both of Charleston; two daughters, Mrs. William S. Stevens of Charleston, and Mrs. William G. Hamm of Atlanta.

LIONELLE DUDLEY WELLS

Dr. Lionelle D. Wells, Sr., 64, prominent physician of Holly Hill, died at Roper Hospital in Charleston, May 18, after an illness of several weeks.

Dr. Wells was born at Wells, May 26, 1884. He received his education in the schools of Orangeburg County and was graduated from Furman University in 1906. Four years later he was graduated from the Medical College of South Carolina. After further study at the medical school of the University of New York, Dr. Wells settled at Holly Hill where he was living at the time of his death.

Dr. Wells is survived by his widow, the former Mary Hughey of Greenwood; two sons, Dr. L. D. Wells, Jr. of Little Rock, Arkansas, and M. H. Wells of Holly Hill; three daughters by a previous marriage.

BIRTHS

Dr. and Mrs. James L. Hughes of Greer have announced the birth of a son, Richard Perry, March 21, in Greenville.

Dr. and Mrs. Henry W. Herbert of Florence have announced the arrival of a son, Henry Williams Herbert, Jr., May 14, in Florence.

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